AMBULANCE TRIP LOG

INITIAL REPORT FORM FOR NON-SCHEDULED TRANSPORTS

Verify Medicaid Eligibility then FAX to the Mountain-Pacific Quality Health Foundation at: 800-291-7791 within 30 days of transport.

Ambulance Name: _____ Provider # _____ Phone: ( )_____

Date:_____ Ambulance Contact Person: _____ FAX#: ( )_____

Patient's Name	Medicaid Number	Sex	Date of Birth	Date of Service	Level of Service	From To	Medical Reason for Transport

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